Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 11, 2019	2019_805638_0028	020330-19	Critical Incident System

Licensee/Titulaire de permis

Extendicare (Canada) Inc.
3000 Steeles Avenue East Suite 103 MARKHAM ON L3R 4T9

Long-Term Care Home/Foyer de soins de longue durée

Extendicare Kapuskasing
45 Ontario Street P.O. Box 460 KAPUSKASING ON P5N 2Y5

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

RYAN GOODMURPHY (638)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): December 4 - 5, 2019.

The following intakes were inspected during this Critical Incident System inspection;
-One log, which was related to an incident of resident to resident physical abuse, which resulted in an injury.

A Complaint inspection #2019_805638_0029 was conducted concurrently with this Critical Incident System inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator/Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW) and residents.

The Inspector also conducted a daily tour of resident home areas, observed the provision of care, staff to resident interactions, reviewed relevant resident health care records as well as home policies and procedures.

The following Inspection Protocols were used during this inspection:
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
2 WN(s)
0 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l’article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident’s care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when, the resident’s care needs changed or care set out in the plan was no longer necessary.

A CIS report was submitted to the Director related to an incident of resident to resident physical abuse which resulted in an injury. The report outlined that resident #002 became physically responsive with resident #001 and as a result resident #001 became physically responsive back, which resulted in resident #002 sustaining an injury requiring intervention.

A) Inspector #638 reviewed resident #001’s health care records and identified in the progress notes, notations where resident #001 and resident #002 had demonstrated responsive behaviours with each other;
-one instance, resident #001 and resident #002 were found by staff demonstrating verbally and physically responsive behaviours towards one another;
-a second instance, resident #001 was verbally responsive towards resident #002 due to resident #002 agitating resident #001;
-a third instance, resident #001 reported that resident #002 had become physically responsive towards them and that they became physically responsive back to resident #002, which resulted in an injury to resident #002; and
-a fourth instance, resident #001 reported that resident #002 had become physically responsive towards them, which resulted in an injury to resident #001.

Inspector #638 reviewed resident #001’s plan of care and although resident #002 was identified as a trigger, there was no identification that resident #001 had the potential to be physically responsive.

B) Inspector #638 reviewed resident #002’s health care records and identified in the progress notes, notations where resident #002 and resident #001 had demonstrated responsive behaviours with each other;
-one instance, resident #002 was verbally accosted by other resident and it was noted by the PSW that the resident defended themselves from resident #001;
-a second instance, resident #002 was found demonstrating responsive behaviours as a result of resident #001. After the incident resident #002 opened resident #001’s door again and was verbally responsive towards resident #001 again;
-a third instance, resident #002 entered resident #001’s room and resident #001 became

verbally responsive towards resident #002 for the accusatory statements they were making, which escalated into both residents becoming verbally responsive with one another; and
-a fourth instance, resident #002 was found sitting in a chair with an area of altered skin integrity due to an incident of physically responsive behaviours between resident #001 and resident #002.

The Inspector reviewed resident #002’s plan of care and was unable to identify the potential to be physically responsive or that resident #001 was a potential trigger for resident #002.

In an interview with Inspector #638, PSW #102 indicated that staff referred to the resident’s care plan for information related to types of behaviours and interventions to manage them. The PSW indicated they would report any behaviours or changes to the Behavioural Support Ontario (BSO) lead.

During an interview with Inspector #638, RPN #101 (BSO lead) indicated that registered staff were in charge of updating the resident’s care plan, which was what staff referred to for resident specific information and interventions. The Inspector reviewed resident #001 and resident #002's plans of care with the RPN, who indicated that they both had a history of physically responsive behaviours with one another. Upon reviewing their plans of care, the Inspector inquired if their potential to become physically responsive should have been identified and the RPN indicated that it should have been identified.

The home’s policy titled “Responsive Behaviours – RC-17-01-04” indicated that the interdisciplinary team was to ensure that the care plan included a description of the behaviour, triggers to the behaviour, preventative measures, resident specific intervention to address the behaviour and strategies staff are to follow when intervention are not effective.

In an interview with Inspector #638, the Administrator/DOC indicated that, new or changing, behaviour related concerns were referred to BSO and staff referred to the resident’s care plan for information which included types of behaviours, triggers and causes. Upon the Inspector reviewing their findings in resident #001 and resident #002’s care plans, the Administrator/DOC indicated that it was a "miss" that the type of behaviour had not been included in these residents’ care plans. [s. 6. (10) (b)]

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident’s money.
5. Misuse or misappropriation of funding provided to a licensee under this Act, the Local Health System Integration Act, 2006 or the Connecting Care Act, 2019.

Findings/Faits saillants :

1. The licensee failed to ensure that a person who had reasonable grounds to suspect that the abuse of a resident by anyone, that resulted in harm, was immediately reported to the Director.

A CIS report was submitted to the Director related to an incident of resident to resident physical abuse which resulted in an injury. Please see WN #1 for details.

Inspector #638 reviewed resident #001's electronic health care records and identified a progress note which outlined another incident that was reported by resident #001 approximately one month after the reported incident. The resident alleged that resident #002 was physically responsive with them again and resident #001 sustained an area of altered skin integrity as a result.

The Inspector reviewed the abuse decision tree, which indicated that if force was applied by a resident to another resident, which resulted in a physical injury, the licensee was to immediately report the incident to the Director.

The Inspector reviewed the home's reported incidents and identified that there was no report related to the aforementioned incident.

In an interview with Inspector #638, PSW #102 indicated that whenever an incident of resident to resident abuse was identified they ensured resident safety and reported the incident to registered staff.

The home's policy titled "Zero Tolerance of Resident Abuse and Neglect Program - RC-02-01-01" last updated June 2019, indicated that all homes will implement a comprehensive zero tolerance of resident abuse and neglect program including measures to promote fulsome and timely internal and external reporting for disclosure.

In an interview with Inspector #638, the Administrator/DOC indicated that the home's reporting process was to report all incidents to the Administrator/DOC and if the incident occurred after hours, registered staff were to complete the after hours call and the Administrator/DOC was to complete the CIS report. Upon reviewing the aforementioned incident, the Administrator/DOC indicated that they were made aware of the incident between resident #001 and resident #002 and the staff "probably should have reported" the incident. [s. 24. (1) 2.]

Issued on this 12th day of December, 2019

Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs

Original report signed by the inspector.